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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

428

01596

CERTIFICATE OF DEATH

Reg. Dist. No.

Springfield State Hospital

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>SYRESVILLE</u> LENGTH OF STAY (in this place) <u>from 7-7-1956</u> TOWN <u>Springfield State Hospital</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>114-2</u> OR TOWN STREET ADDRESS (If rural give location) <u>GARRETT CO.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ETTIE</u> <u>ARENHOLT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>22</u> <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>8-24-1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NO OCCUPATION</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>GARRETT COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>KITZMILLER</u>				14. MOTHER'S MAIDEN NAME <u>MARY S. ARENHOLT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.2 IMMEDIATE CAUSE (A) Bronchopneumonia</u>						<u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>cardiac insufficiency</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epilepsy with deterioration</u>						<u>76 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-21</u> , 19 <u>56</u> , to <u>1-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>56</u> , and that death occurred at <u>2</u> <u>A</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>Juleson Radzykewicz</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>1/30/56</u>		<u>1/30/56</u>		<u>St. Mary's Med. School</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 15 1956</u>		REGISTRAR'S SIGNATURE <u>E. Harry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CLERK

13. SIGNATURE OF CHURCH CLERK

14. SIGNATURE OF BURIAL CLERK

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DEPARTMENT OF HEALTH - BALTIMORE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. S.

FEB 16 1956

RECEIVED

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

429

CERTIFICATE OF DEATH

00415

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		LENGTH OF STAY (In this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>		STREET ADDRESS <u>123 S. Caroline Street</u>		(If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> <u>Ralph</u> <u>Banks</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>19</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>1-17-1907</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>King & Queen's Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-3398</u>		17. INFORMANT & ADDRESS <u>Thomas R. Banks - 123 S. Caroline St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Extensive pulmonary hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Far advanced pulmonary tuberculosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Far advanced pulmonary tuberculosis</u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-12-</u> <u>19 56</u> , to <u>1-19-</u> <u>19 56</u> , that I last saw the deceased alive on <u>1-19-</u> <u>19 56</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>T.F. Resal</u> M.D. <u>Henryton State Hospital</u> DATE SIGNED <u>1-19-56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel County</u>	
24. REC'D BY REGISTRAR DATE <u>1-19-56</u>		REGISTRAR'S SIGNATURE <u>Albert R. Swan</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Elroy Wilson - 1000 Brantley Avenue</u>			

CERTIFICATE OF DEATH

1-2

10415

1. NAME OF DECEASED (Print or Write)

MARYLAND

DATE OF DEATH

PLACE OF DEATH

2. SEX (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

3. OCCUPATION (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

4. CAUSE OF DEATH (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

5. MANNER OF DEATH (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

6. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

7. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

8. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

9. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

10. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

11. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

12. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

13. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

14. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

15. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

16. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

17. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

18. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

19. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

20. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

21. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

22. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

23. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

24. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

25. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

26. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

27. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

28. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

29. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

30. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

31. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

32. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

33. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

34. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

35. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

36. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

37. SIGNATURE OF DECEASED (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

38. SIGNATURE OF PHYSICIAN (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

39. SIGNATURE OF REGISTRAR (Print or Write)

DATE OF DEATH

PLACE OF DEATH

EDUCATION

40. SIGNATURE OF WITNESS (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00416

430

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>11mo. 19days</u>		TOWN <u>Taneytown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>HARRY</u> <u>CLIFTON</u> <u>BAUMGARDNER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 2</u> <u>19</u> <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>11-7-1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Baumgardner</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Pearl Spielman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Diabetic Coma</u>						<u>20 hrs. +</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Hypertension</u>						<u>1 yr. +</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Schizophrenic reaction, chronic undifferentiated type.</u>						<u>1yr.+</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1</u> , 19 <u>56</u> , to <u>1-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>56</u> , and that death occurred at <u>1:00A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeld</u>		ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1-2-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/5/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Gettysburg, Adams Co., Pa.</u>	
24. REC'D BY REGISTRAR DATE <u>1-4-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Weber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Little & Son</u> <u>P. R. A. Little</u> ADDRESS <u>Littlestown, Pa.</u>			

00110

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1956

Form 10-1-56

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. PLACE OF BIRTH

7. MARRIAGE

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PLACE OF DEATH

12. DATE OF DEATH

13. TIME OF DEATH

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF CLERK

21. SIGNATURE OF NOTARY

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF JAILER

25. SIGNATURE OF WARDEN

26. SIGNATURE OF CHIEF OF POLICE

27. SIGNATURE OF DEPUTY CHIEF OF POLICE

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF JAILER

31. SIGNATURE OF WARDEN

32. SIGNATURE OF CHIEF OF POLICE

33. SIGNATURE OF DEPUTY CHIEF OF POLICE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF JAILER

37. SIGNATURE OF WARDEN

38. SIGNATURE OF CHIEF OF POLICE

39. SIGNATURE OF DEPUTY CHIEF OF POLICE

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF DEPUTY SHERIFF

42. SIGNATURE OF JAILER

43. SIGNATURE OF WARDEN

44. SIGNATURE OF CHIEF OF POLICE

45. SIGNATURE OF DEPUTY CHIEF OF POLICE

BUREAU V. S.

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00417

421

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Westminster</u>		<u>30yrs.</u>		TOWN <u>Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>99 1/2 Liberty Street</u>				<u>99 1/2 Liberty Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MAE A. Beegle</u>				<u>January 28 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>Sept. 21, 1870</u>	<u>85</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Bedford Co. Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Harvey Shaffer</u>				<u>Arbannah Rollins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>55-213-12-7796</u>		<u>Mrs Mervin Close Westminster Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Cardiovascular Renal disease</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertension & Myocardial</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>degeneration</u>			
STATING UNDERLYING CAUSE LAST, DUE TO				<u>Arterio-sclerosis General</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>6 mo</u>			
				<u>several yrs</u>			
				<u>several yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1955</u> , to <u>Jan 28, 1956</u> , that I last saw the deceased alive on <u>Jan 27, 1956</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town; state)		DATE SIGNED	
<u>Walter Speicher</u>				<u>Westminster Md</u>		<u>1/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Feb. 1, 1956</u>		<u>Friends Cove Cem.</u>		<u>Bedford Co. Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>2-1-56</u>		<u>Harriet Miller</u>		<u>Bankard Son Westminster, Md.</u>			

BUREAU V. S.

FEB 6 1956

RECEIVED

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INSTRUCTIONS

MB

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00418

431

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>5Y 1M 13 days</u>		TOWN <u>Williamsport</u>		<u>218-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William Albert BENTZ</u>				<u>1/ 5 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>single</u>	<u>4/ 8/ 1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Pharmacist</u>		<u>Pharmacy</u>		<u>Gettysburg, Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME <u>William Bentz</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Culp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>unknown</u>		<u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>5 years +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>56</u> , to <u>1/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>56</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Gettysburg, Adams Co. Pa.</u>	
24. REC'D BY REGISTRAR <u>Jan. 10, 1956</u>		REGISTRAR'S SIGNATURE <u>C. Harry Ewell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Miller</u>		ADDRESS <u>Gettysburg, Pa.</u>	

BUREAU V. S.

RECEIVED

JAN 11 1917

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 35	
4. DATE OF DEATH Jan 10 1917		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Pneumonia	
7. PLACE OF BIRTH Arkansas		8. DATE OF BIRTH Jan 15 1882		9. OCCUPATION Farmer	
10. MARITAL STATUS Married		11. EDUCATION High School		12. PREVIOUS ILLNESS None	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF WITNESSES J. H. Harris, J. H. Harris		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF CLERK J. H. Harris		18. SIGNATURE OF JURY J. H. Harris	

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00419

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Louisville		life		TOWN Louisville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg R 1				STREET ADDRESS (If rural give location) Finksburg R 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) George (Middle) Ray (Last) Bitzel				(Month) Jan. (Day) 29 (Year) 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 26, 1883	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Carroll County, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Bitzel				14. MOTHER'S MAIDEN NAME Elizabeth Crooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS Howard Bitzel Finksburg, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Infarction				6 hours			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery disease				4 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rheumatoid Arthritis				10 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 29, 1956 to Jan 29, 1956 , that I last saw the deceased alive on Jan 29, 1956 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE James J. Morsch				DATE SIGNED 1/30/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Feb. 1, 1956		NAME OF CEMETERY OR CREMATORY Trinity Lutheran	
				LOCATION (City, town, or county) Smallwood, Maryland			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Harriet Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.		ADDRESS	
DATE 2-2-56							

CERTIFICATE OF DEATH

Reg. No. 124

1. Usual Residence Home or Office

2. Date of Death

3. Time of Death

4. Place of Death

5. Name of Deceased

6. Sex

7. Age

8. Race

9. Birth Date

10. Birth Place

11. Cause of Death

12. Immediate Cause

13. Intermediate Cause

14. Remote Cause

15. Duration of Illness

16. Name of Physician

17. Name of Hospital

18. Name of Undertaker

19. Name of Burial Place

20. Name of Interment

21. Name of Cemetery

22. Name of Funeral Home

23. Name of Mortician

24. Name of Embalmer

25. Name of Burial Place

26. Name of Interment

27. Name of Cemetery

28. Name of Funeral Home

29. Name of Mortician

30. Name of Embalmer

31. Name of Burial Place

32. Name of Interment

33. Name of Cemetery

34. Name of Funeral Home

35. Name of Mortician

36. Name of Embalmer

37. Name of Burial Place

38. Name of Interment

39. Name of Cemetery

40. Name of Funeral Home

41. Name of Mortician

42. Name of Embalmer

43. Name of Burial Place

44. Name of Interment

45. Name of Cemetery

46. Name of Funeral Home

47. Name of Mortician

48. Name of Embalmer

BUREAU V. S.

FEB 6 19

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN ORDER OF THE COMMISSIONER OF HEALTH. IT IS THE DUTY OF THE UNDERTAKER TO FURNISH A TRUE AND CORRECT COPY OF THIS CERTIFICATE TO THE BURIAL PLACE AND TO THE FUNERAL HOME. IT IS THE DUTY OF THE FUNERAL HOME TO FURNISH A TRUE AND CORRECT COPY OF THIS CERTIFICATE TO THE BURIAL PLACE AND TO THE INTERMENT. IT IS THE DUTY OF THE BURIAL PLACE TO FURNISH A TRUE AND CORRECT COPY OF THIS CERTIFICATE TO THE INTERMENT. IT IS THE DUTY OF THE INTERMENT TO FURNISH A TRUE AND CORRECT COPY OF THIS CERTIFICATE TO THE COMMISSIONER OF HEALTH.

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00460

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carron Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carron</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Westminster</u>		<u>68 yrs.</u>		TOWN <u>Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>59 Union St.</u>				STREET ADDRESS (If rural give location) <u>59 Union St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EDNA</u> (Middle) <u>MAE</u> (Last) <u>CHARMS</u>				(Month) <u>JAN.</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>f.</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 16 1887?</u>	9. AGE last birthday <u>68?</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Westminster Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Bruce</u>				14. MOTHER'S MAIDEN NAME <u>Susie Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-3988</u>		17. INFORMANT & ADDRESS <u>Joseph Chums, Westminster Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Carcinoma Rectum</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5-6 mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>& Metastases anemia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>& Cachexia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Sept 16/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Rectum - obstruction performed</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 17, 1955</u> , to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan 17, 1956</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>William Speicher</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster Md.</u>		DATE SIGNED <u>Jan 24-1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 27, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkworth Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural, Westminster Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Waller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Myers, Jr.</u>		ADDRESS <u>Westminster Md.</u>	
DATE <u>2-24-56</u>							

CERTIFICATE OF DEATH

100-100000

1. DEATH CERTIFICATE NUMBER

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF OF POLICE

23. SIGNATURE OF DETECTIVE

24. SIGNATURE OF INSPECTOR

25. SIGNATURE OF SUPERVISOR

26. SIGNATURE OF OFFICER

27. SIGNATURE OF CONSTABLE

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

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58. SIGNATURE OF DEPUTY SHERIFF

59. SIGNATURE OF JAILER

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62. SIGNATURE OF DETECTIVE

63. SIGNATURE OF INSPECTOR

64. SIGNATURE OF SUPERVISOR

65. SIGNATURE OF OFFICER

66. SIGNATURE OF CONSTABLE

67. SIGNATURE OF JURY

68. SIGNATURE OF JUDGE

69. SIGNATURE OF CLERK

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71. SIGNATURE OF DEPUTY SHERIFF

72. SIGNATURE OF JAILER

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74. SIGNATURE OF CHIEF OF POLICE

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76. SIGNATURE OF INSPECTOR

77. SIGNATURE OF SUPERVISOR

78. SIGNATURE OF OFFICER

79. SIGNATURE OF CONSTABLE

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85. SIGNATURE OF JAILER

86. SIGNATURE OF WARDEN

87. SIGNATURE OF CHIEF OF POLICE

88. SIGNATURE OF DETECTIVE

89. SIGNATURE OF INSPECTOR

90. SIGNATURE OF SUPERVISOR

91. SIGNATURE OF OFFICER

92. SIGNATURE OF CONSTABLE

93. SIGNATURE OF JURY

94. SIGNATURE OF JUDGE

95. SIGNATURE OF CLERK

96. SIGNATURE OF SHERIFF

97. SIGNATURE OF DEPUTY SHERIFF

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-55 10M

00421

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Carroll</i>	MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN) <i>Westminster</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Westminster</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>44 Longwell Ave.</i>	LENGTH OF STAY (In this place) <i>9 yrs</i>	STREET ADDRESS (If rural give location) <i>44 Longwell Ave.</i>	
3. NAME OF DECEASED (First) (Middle) (Last) <i>GRACE GILBERT DAILEY</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 22 1956</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>July 1, 1883</i>
9. AGE last birthday <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Wesley Dailey</i>		14. MOTHER'S MAIDEN NAME <i>Annie Louisa Owsen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Mrs. Claude J. Kinney Westminster, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>Edema of Lungs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>chronic rheumatoid arthritis</i>		<i>5 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>diabetes</i>		<i>5 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Apr. 15, 1955</i> , to <i>Jan. 21, 1956</i> , that I last saw the deceased alive on <i>Jan. 21, 1956</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>C. B. Jennings</i> M.D.		DATE SIGNED <i>1-23-56</i>	
ADDRESS (Street, city, town, state) <i>Westminster, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial Jan. 25, 56 Westminster Cemetery Westminster, Md.</i>		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Harriet Muller</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. S. Myers Jr., Westminster, Md.</i>	
DATE <i>1-24-56</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence at time of death

7. Usual occupation

8. Cause of death (Print or write full name)

9. Date of death

10. Time of death

11. Place of death

12. Signature of physician

13. Signature of coroner

14. Signature of registrar

15. Signature of informant

16. Signature of witness

17. Signature of funeral director

18. Signature of undertaker

19. Signature of cemetery

20. Signature of burial place

21. Signature of interment

22. Signature of burial

23. Signature of funeral

24. Signature of service

25. Signature of burial

26. Signature of interment

27. Signature of burial

28. Signature of interment

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47. Signature of burial

48. Signature of interment

NOT QUOTED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT.

BUREAU V. S.

JAN 26 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00422

433

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Rural - Sykesville		since 10-11-55		TOWN Woodbine		13X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital				STREET ADDRESS (If rural give location) ---			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Albert (Middle) Stars (Last) DUVALL				(Month) January (Day) 26 (Year) 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	July 12, 1878	77 yrs.	Months -	Days -	Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farming		Woodbine, Maryland		United States	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Albert Stars Duvall				Armanello -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		unknown		Records of Springfield State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) Cerebrovascular accident with left hemiplegia						10 days	
ANTECEDENT CAUSE(S) DUE TO (B) ---							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) ---							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome assoc. with circulatory disturbance with cerebral arteriosclerosis, with psychotic reaction.						about 1 1/2 yr.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ---			
---		M.					
22. I hereby certify that I attended the deceased from Nov. 29, 19 55 , to Jan. 25, 19 56 , that I last saw the deceased alive on Jan. 25, 19 56 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Martin Gross, M.D.				Sykesville, Md.		1/26/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
BURIAL	JAN. 29.	Jennings Chapel		HOWARD Co.		MD.	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Jan. 30, 1956	C. Henry Edger			Roy W. Barber		Laytonville Md.	

BUREAU V. S.

1956 FEB 1

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00423

424

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MD</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
TOWN <u>WESTMINSTER</u>		LENGTH OF STAY (in this place) <u>68 YRS.</u>		TOWN <u>WESTMINSTER</u>		TOWN <u>WESTMINSTER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>23 W. GEORGE</u>				STREET ADDRESS (If rural give location) <u>23 W. GEORGE</u>			
3. NAME OF DECEASED (Type or Print) <u>VERNON STONER ECKENRODE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-16-56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>11-18-1887</u>	
9. AGE last birthday <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shorthand book & body works</u>		11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. ECKENRODE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE STONER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-22-4564</u>		17. INFORMANT & ADDRESS <u>MARY ECKENRODE 23 W. George Westminster Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
421.4 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						5 MINUTES	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Valvular Heart Disease</u>						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1948</u> , to <u>Jan 16, 1956</u> , that I last saw the deceased alive on <u>Jan 16, 1956</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Julius Chapiro</u>				ADDRESS (Street, city, town, state) <u>Westminster Md</u>		DATE SIGNED <u>1/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-19-1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Muller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H Bankard</u>		ADDRESS <u>Don Westminster Md.</u>	
DATE <u>1-19-56</u>							

1953

BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DATE OF DEATH

REGISTRATION - PART OF DEATH

STATE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

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STATE OF BIRTH

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BUREAU V. S.

JAN 23 1956

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MARYLAND

434

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyksville</u> LENGTH OF STAY (in this place) <u>50 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyksville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Nannie Furtth Ealy</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 10 1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 14, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>George Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Clara Curkey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Unk.</u>	
17. INFORMANT AND ADDRESS <u>Carroll D. Ealy - Hyksville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

1 wk

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)
SUICIDE
HOMICIDEPLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from 1/11/1956, to 1/10/1956, that I last saw the deceasedalive on 1/9/1956, and that death occurred at 2:15 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ann. E. Martin M.D.Randallstown Md1/11/56

23. BURIAL, CREMATION REMOVAL. (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 12, 1956C. Harry AllenArthur H. Haight - Hyksville, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 16 1936

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00425

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>24 days</u>		TOWN <u>Baltimore</u>		<u>3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>314 E. 25th St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Pierre G. Gaspari</u>				<u>1- 22 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>1879</u>	<u>70/7 76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>				<u>Unknown</u>		<u>Unknown</u>	
13. FATHER'S NAME <u>Peter Gaspari</u>				14. MOTHER'S MAIDEN NAME <u>Mary Preston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unknown</u>				<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral vascular thrombosis</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Hypertensive cardio vas. disease, C.B.S. associated with senile brain disease with psychotic reactions</u>						<u>years months.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-29-</u> , 19 <u>55</u> , to <u>1-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-22=</u> , 19 <u>56</u> , and that death occurred at <u>3</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Townsend</u>				ADDRESS (Street, city, town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>1-22-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 25 1956</u>		REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Liebner & Son - Balto. Md.</u>		ADDRESS	
DATE							

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BUREAU V. S.

JAN 24 1956

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INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00426

436

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural--New Windsor</u>		LENGTH OF STAY (in this place) <u>2 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural--Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>R.F.D. #6</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>THOMAS G. HAINES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-30 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>5-23-1872</u>	
9. AGE last birthday <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Elhanan A. Haines</u>				14. MOTHER'S MAIDEN NAME <u>Edith A. Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Woodrow Haines, New Windsor, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arterio sclerotic C-V disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>year -</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>CAUSE OF DEATH</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 1955</u> to <u>Jan 30 1956</u> that I last saw the deceased <u>Jan 29 1956</u> alive on <u>Jan 29 1956</u> and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. Marsh</u>				DATE SIGNED <u>1/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>2-1-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Sams Creek Brethren</u>	
24. REC'D BY REGISTRAR				LOCATION (City, town, or county) <u>Carroll Co., Maryland</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Winfield, Maryland</u>	
REGISTRAR'S SIGNATURE <u>E. M. Farver</u>				ADDRESS			
DATE <u>2-1-1956</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

180

DATE OF DEATH

PLACE WHERE DEATH OCCURRED

DECEASED'S NAME

MARYLAND

DECEASED'S ADDRESS

DECEASED'S AGE

SEX

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S RACE

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

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BUREAU V. S.

FEB 3 1956

RECEIVED

NOTIFICATION

1. A death certificate is a legal document that provides information about a person's death. It is used for legal, medical, and statistical purposes. The information on a death certificate includes the date and place of death, the cause of death, and the identity of the deceased. Death certificates are required for many legal and administrative processes, such as obtaining a burial permit, claiming life insurance, and filing for taxes. In Maryland, death certificates are issued by the State Department of Health. The information on a death certificate is used to monitor and control the spread of infectious diseases, to study the causes of death, and to plan for the future. Death certificates are also used to provide information about the health of the population. In Maryland, death certificates are issued by the State Department of Health. The information on a death certificate is used to monitor and control the spread of infectious diseases, to study the causes of death, and to plan for the future. Death certificates are also used to provide information about the health of the population.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00427

437

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		since <u>3-14-51</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>4114 Eierman Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Frederic</u> (Middle) <u>Atherton</u> (Last) <u>Hamilton</u>				(Month) <u>Jan.</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M.</u>	<u>W.</u>	<u>wid.</u>	<u>7-25-70</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>minister</u>		<u>Church</u>		<u>Indiana</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Hamilton</u>				<u>Elizabeth Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>7426</u>		<u>Records of Springfield State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>4500</u> IMMEDIATE CAUSE (A) <u>mesenteric Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary occlusion</u>				<u>about 1 day</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerosis</u>				<u>minutes</u>			
DUE TO <u>kyphoscoliosis</u>				<u>more than 5 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>manic depr. psychosis, manic type, senile changes</u>				<u>5 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u>, 19<u>51</u>, to <u>Jan. 8</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan. 7</u>, 19<u>56</u>, and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				DATE SIGNED <u>Jan. 8, 1956</u>			
<u>Martin Gross, M.D.</u>				<u>Sykesville, Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Cremation</u>		<u>1-11-56</u>		<u>Greenmount</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 8, 1956</u>		<u>C. Harry Tucker</u>		<u>John M. Smith - 4210 Bellvue Rd. N.W.</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Medical Residence (House or Place)

County

2. Date of Death

3. Place of Death

4. Cause of Death

5. Nature of Injury

6. Name of Physician

7. Name of Hospital

8. Name of Doctor

9. Name of Nurse

10. Name of Undertaker

11. Name of Burial Place

12. Name of Cemetery

13. Name of Registrar

14. Name of Informant

15. Name of Informant

16. Name of Informant

17. Name of Informant

18. Name of Informant

19. Name of Informant

20. Name of Informant

21. Name of Informant

BUREAU V. S.

JAN 11 1936

RECEIVED

NOTATIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00428

438

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Rural - Sykesville</u>		<u>7Y, 9M, 29Days</u>		TOWN <u>Westminster</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Ella Haney</u>				<u>1 3 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>single</u>	<u>3/3/67</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Huntington, Indiana</u>		<u>USA</u>	
13. FATHER'S NAME <u>Peter Haney</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Foster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>Unk.</u>		<u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute Myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>pulmonary edema</u>						<u>hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with senile brain disease, with psychosis</u>						<u>8 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/1</u> , 19 <u>56</u> , to <u>1/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/3</u> , 19 <u>56</u> , and that death occurred at <u>3:13 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sommerfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7. 56</u>		NAME OF CEMETERY OR CREMATORY <u>Leiston Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural, Westminster Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Waver</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Snyder, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>Jan. 8, 1956</u>							

10101

MINISTRE DE LA SANTE - DEPARTMENT OF HEALTH - BUREAU V. 2

CERTIFICATE OF DEATH

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BUREAU V. 2

JAN 11 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00429

439

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>York</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Manchester</u>		<u>9 months</u>		TOWN <u>HANOVER, Penna</u>		<u>75x3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Longview Nursing Home</u>				STREET ADDRESS (If rural give location) <u>21 Fourth St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HARRY N. HEUSNER</u>				<u>JANUARY 18 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>M.</u>	<u>October 20, 1866</u>		<u>89</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>CIGAR MAKER</u>		<u>TOBACCO</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HEZEKIAH HEUSNER</u>				<u>MIRIA ERISMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>106-14-2282</u>		<u>MRS H.F. MAHALEY - HANOVER Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u></u>							
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardio-vascular Disease</u></u>							
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bridge, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 24, 1955</u>, to <u>JANUARY 18, 1956</u>, that I last saw the deceased alive on <u>JANUARY 17, 1956</u>, and that death occurred at <u>5:44 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u>				ADDRESS (Street, city, town, state) <u>Hanover Pa</u>			
DATE <u>Jan 20-56</u>				DATE SIGNED <u>1-18-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/20/56</u>		<u>Mt Olivet Cem</u>		<u>Hanover Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 20-56</u>		<u>Mrs H.F. Denner</u>		<u>Frederick Bucher</u>		<u>Hanover Pa</u>	

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INSTRUCTIONS

MB

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00430

440

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>14</u> Y, <u>9</u> M, <u>23</u> days		TOWN <u>Rural - Hagerstown</u>		<u>21x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EDNA</u>		(Middle)		(Last) <u>HOFFMAN</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>12/25/89</u>	
				9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>1</u> (Days) <u>19</u> (Year) <u>19</u> <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aaron Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>491X Bronchopneumonia, unresolved</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				Years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Mental Deficiency without psychosis</u>				since birth			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/11</u> , 19 <u>55</u> , to <u>1/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem</u>		LOCATION (City, town, or county) <u>Hagerstown Md</u>	
24. REC'D BY REGISTRAR <u>Jan. 20, 1956</u>		REGISTRAR'S SIGNATURE <u>C. Harry Weir</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Hoffman</u>		ADDRESS <u>Hagerstown Md.</u>	

104406

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE

11. DATE

12. PLACE OF DEATH

13. SIGNATURE

14. DATE

15. PLACE OF DEATH

16. SIGNATURE

17. DATE

18. SIGNATURE

19. DATE

20. PLACE OF DEATH

21. SIGNATURE

22. MANNER OF DEATH

23. SIGNATURE

24. PLACE OF DEATH

25. SIGNATURE

26. DATE

27. PLACE OF DEATH

28. PLACE OF DEATH

29. SIGNATURE

30. DATE

31. SIGNATURE

32. DATE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00431

441

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 2, Film G191 1-24-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville-Rural</u>		<u>4 mos</u>		TOWN <u>Sykesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Grand View Mansion</u>				STREET ADDRESS <u>1111 Housleyville Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>JENNIE - R - Houseman</u>				(Month) (Day) (Year) <u>Jan 14 - 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec 14 - 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hwr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jacob W. Dehoff</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Royer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-24-8301</u>		17. INFORMANT & ADDRESS <u>William Houseman</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <u>adenocarcinoma of cervix with</u>						<u>1 yr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases to adnexa -</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized carcinomatosis</u>						<u>4 mos</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14</u> , 19 <u>55</u> , to <u>Jan 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>56</u> , and that death occurred at <u>12:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. J. Jansen</u>		M.D. <u>Sykesville, Maryland</u>		ADDRESS (Street, city, town, state) <u>1111 Housleyville Ave</u>		DATE SIGNED <u>1/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) <u>Carroll Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. A. Tipton</u>		ADDRESS <u>Hampstead Md</u>	
DATE <u>Jan 17, 1956</u>							

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00432

442

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		LENGTH OF STAY (in this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ELGER ST.</u>				STREET ADDRESS (If rural give location) <u>ELGER ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>LULA BLANCHE JUNG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 25 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>9/4/1882</u>		9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH MCKINNEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE BAER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-05-8941</u>		17. INFORMANT & ADDRESS <u>MRS FENTON YINGLING-UNION BRIDGE MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Acute Myocardial failure</u>						<u>None</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C-V disease</u>						<u>year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 25</u> , 19 <u>56</u> , to <u>Jan 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. Marsh</u>				ADDRESS (Street, city, town, state) <u>Union Bridge Md</u>		DATE SIGNED <u>1/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/28/56</u>		NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>UNION TOWN-MD.</u>	
24. REC'D BY REGISTRAR <u>Jan 28, 1956</u>		REGISTRAR'S SIGNATURE <u>John S. Rapp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. HARTZLER & SONS</u>		ADDRESS <u>UNION BRIDGE MD.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

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43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

BUREAU V. S.

JAN 30 1956

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

443

1. PLACE OF DEATH COUNTY <u>CARROLL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> LENGTH OF STAY (in this place) <u>since 6/10/55</u> TOWN <u>Sykesville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto-City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>City 37014</u> STREET ADDRESS (If rural give location) <u>1005 S. Belnoid Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>HENRY BERNARD KALBFLEISCH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-12-56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-3-98</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John H. Kalbfleisch</u>				14. MOTHER'S MAIDEN NAME <u>TERESA Kalbfleisch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>UNK.</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Kalbfleisch</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u> ANTECEDENT CAUSE(S) DUE TO <u>ARTERIOSCLEROSIS</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>more than 6 mos.</u> (C)						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>AR CBS associated with arteriosclerosis, with psychotic reaction</u>						about <u>2 yrs.</u>	
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>6-17-55</u> to <u>1-12-56</u> , that I last saw the deceased alive on <u>1-12-56</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 17/1956</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		LOCATION (City, town, or county) (State) <u>GERMAN HILL RD, MD</u>	
24. REC'D BY REGISTRAR <u>JAN 16 1956</u>		REGISTRAR'S SIGNATURE <u>C. Harry Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marine Lialkowski</u>		ADDRESS <u>1000 S. Kenwood Ave Baltimore</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 100-100

AT LOCAL RESIDENCE, NORTH ST. 100-100

DATE OF DEATH 100-100

TIME OF DEATH 100-100

PLACE OF DEATH 100-100

CAUSE OF DEATH 100-100

MANNER OF DEATH 100-100

AGE 100-100

SEX 100-100

RACE 100-100

EDUCATION 100-100

OCCUPATION 100-100

RELIGION 100-100

PREVIOUS ILLNESS 100-100

PREVIOUS SURGERY 100-100

PREVIOUS TRAUMA 100-100

PREVIOUS DRUGS 100-100

PREVIOUS ALCOHOL 100-100

PREVIOUS TOBACCO 100-100

PREVIOUS OTHER 100-100

PREVIOUS OTHER 100-100

PREVIOUS OTHER 100-100

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BUREAU V. S.

JAN 16 1950

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NOTICE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-00 BY 100-100

MARYLAND STATE DEPARTMENT OF HEALTH

00434

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Annie</u> (Middle) <u>Elizabeth</u> (Last) <u>Keefer</u>	4. DATE OF DEATH Jan. 16, 1956	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 4, 1865</u> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Valentine Harman</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. John Price, Taneytown, Maryland</u>	

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Bronchopneumonia, Bilateral.</u>		<u>24 hrs.</u>
(b) <u>Chronic Myocarditis and Myocardial Degeneration</u>		<u>12 yrs.</u>
(c) <u>Generalized Arteriosclerosis</u> <u>Recurrent Malaria</u>		<u>20 yrs.</u> <u>2 wks.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>12/10</u> , 19 <u>42</u> , to <u>1/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/16</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> m., from the causes and on the date stated above.		
SIGNATURE <u>R. A. McVaugh</u> (Degree or title) <u>M.D.</u>		DATE SIGNED <u>1/17/56</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATOR
<u>Burial</u>	<u>1/19/1956</u>	<u>Lutheran Cemetery</u>
DATE REC'D BY LOCAL REG. <u>Jan 18, 1956</u>	REGISTRAR'S SIGNATURE <u>Ethel M. Mahoney</u>	24. FUNERAL DIRECTOR ADDRESS <u>C.O. Fuss & Son, Taneytown, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 20 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00435 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CARROLL		MARYLAND		STATE MARYLAND		COUNTY CARROLL	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN UNION MILLS		18 MONTHS		TOWN UNION MILLS			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEADOW VIEW NURSING HOME							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
FLORENCE DECATUR KIRK				Jan. 6 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOW	2/25/1882	73 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if (retired))		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
HOUSEKEEPER		AT HOME		PENNSYLVANIA		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN W. WHITE				MARY ANNA LARGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		NONE		F. KEPPEL - TANEY TOWN MD			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				Acute Cerebral Hemorrhage			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Chronic Hypertensive Disease			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				24 hrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/5 1956, to 1/6 1956, that I last saw the deceased alive on 1/6 1956, and that death occurred at 4:20 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Dorothy Barr M.D.				1/7/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		1/9/56		WEST LAUREL HILL		PHILADELPHIA, PA.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
1-9-56		Harold Miller		DDHARTZLERYSONS		NEW KINGSAR MD	

BUREAU V. S.

JAN 12 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

447

CERTIFICATE OF DEATH

00436

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster		LENGTH OF STAY (in this place) 2 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 6 Gist Road				STREET ADDRESS (If rural give location) R 6 Gist Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Russell		(Middle) Lowell		(Last) Law		(Month) Jan. (Day) 23 (Year) 1956	
5. SEX Male	6. RACE OR COLOR White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 13, 1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Agent			10b. KIND OF BUSINESS OR INDUSTRY Life Insurance		11. BIRTHPLACE (State or foreign country) Lawford, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Martin L. Law				14. MOTHER'S MAIDEN NAME Mary M. McKinley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) yes			16. SOCIAL SECURITY NO. WW1 219-32-2601		17. INFORMANT & ADDRESS Mrs. Russell L. Law Westminster, Md.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) CORONARY Occlusion						4 hrs -	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) CORONARY ARTERY DISEASE						7	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 22, 1956 , to Jan 23, 1956 , that I last saw the deceased alive on Jan 23, 1956 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.							
SIGNATURE Guides J. March		M.D. Westminster Md		ADDRESS (Street, city, town, state) nr Uniontown, Md.		DATE SIGNED 1/23/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Jan. 25, 1956		NAME OF CEMETERY OR CREMATORY Pipe Creek		LOCATION (City, town, or county) (State) nr Uniontown, Md.	
24. REC'D BY REGISTRAR DATE 1-26-56		REGISTRAR'S SIGNATURE H. Amst Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	

CERTIFICATE OF DEATH

113

00438

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF CLERK

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF DEPUTY SHERIFF

23. SIGNATURE OF CONSTABLE

24. SIGNATURE OF JAILER

25. SIGNATURE OF WARDEN

26. SIGNATURE OF CHIEF CLERK

27. SIGNATURE OF DEPUTY CHIEF CLERK

28. SIGNATURE OF RECORDS CLERK

29. SIGNATURE OF FILE CLERK

30. SIGNATURE OF INDEX CLERK

31. SIGNATURE OF CLERK IN CHARGE

32. SIGNATURE OF CLERK

33. SIGNATURE OF CLERK

34. SIGNATURE OF CLERK

35. SIGNATURE OF CLERK

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF CLERK

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF DEPUTY SHERIFF

23. SIGNATURE OF CONSTABLE

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28. SIGNATURE OF RECORDS CLERK

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30. SIGNATURE OF INDEX CLERK

31. SIGNATURE OF CLERK IN CHARGE

32. SIGNATURE OF CLERK

33. SIGNATURE OF CLERK

34. SIGNATURE OF CLERK

35. SIGNATURE OF CLERK

BUREAU V. S.

JAN 30 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00437

448

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 1 Sandymount		STREET ADDRESS (If rural give location) R 1 Sandymount					
3. NAME OF DECEASED (First) (Middle) (Last) Ada Tresa Lockard				4. DATE OF DEATH (Month) (Day) (Year) Jan. 7 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 26, 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Finksburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Flater				14. MOTHER'S MAIDEN NAME Matilda Bloom			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. -		17. INFORMANT & ADDRESS C. Edgar Lockard Finksburg, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) Uremic Coma						INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSE(S) DUE TO (B) Cardio-Renal-Vascularis Degeneration						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Senility							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or INJURY, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 31, 1953, to Jan. 7, 1956, that I last saw the deceased alive on Jan. 6, 1956, and that death occurred at 9:15 M, from the causes and on the date stated above.							
SIGNATURE D. B. Billingsale		M.D.		ADDRESS (Street, city, town, state) Westminster, Md.		DATE SIGNED 1-8-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 10, 1956		NAME OF CEMETERY OR CREMATORY Pleasant Grove		LOCATION (City, town, or county) (State) Sandymount, Maryland	
24. REC'D BY REGISTRAR DATE 1-9-56		REGISTRAR'S SIGNATURE Harriet Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.			

CERTIFICATE OF DEATH

448

Reg. Dist. No.

1. LOCAL HEALTH OFFICER'S SIGNATURE

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF HEALTH OFFICER

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DISTRICT ATTORNEY

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF VILLAGE CLERK

24. SIGNATURE OF CITY CLERK

25. SIGNATURE OF STATE CLERK

26. SIGNATURE OF NATIONAL CLERK

27. SIGNATURE OF INTERNATIONAL CLERK

28. SIGNATURE OF UNITED NATIONS CLERK

29. SIGNATURE OF WORLD CLERK

30. SIGNATURE OF GALAXY CLERK

31. SIGNATURE OF UNIVERSE CLERK

32. SIGNATURE OF COSMOS CLERK

33. SIGNATURE OF NATURE CLERK

34. SIGNATURE OF SKY CLERK

35. SIGNATURE OF EARTH CLERK

36. SIGNATURE OF WATER CLERK

37. SIGNATURE OF FIRE CLERK

38. SIGNATURE OF AIR CLERK

39. SIGNATURE OF SPACE CLERK

40. SIGNATURE OF TIME CLERK

41. SIGNATURE OF MATTER CLERK

42. SIGNATURE OF ENERGY CLERK

43. SIGNATURE OF INFORMATION CLERK

44. SIGNATURE OF KNOWLEDGE CLERK

45. SIGNATURE OF WISDOM CLERK

46. SIGNATURE OF TRUTH CLERK

47. SIGNATURE OF JUSTICE CLERK

48. SIGNATURE OF PEACE CLERK

49. SIGNATURE OF LOVE CLERK

50. SIGNATURE OF HARMONY CLERK

51. SIGNATURE OF BEAUTY CLERK

52. SIGNATURE OF GOOD CLERK

53. SIGNATURE OF HAPPINESS CLERK

54. SIGNATURE OF HOPE CLERK

55. SIGNATURE OF FAITH CLERK

56. SIGNATURE OF CHARITY CLERK

57. SIGNATURE OF KINDNESS CLERK

58. SIGNATURE OF COURTESY CLERK

59. SIGNATURE OF GRACE CLERK

60. SIGNATURE OF GENTLENESS CLERK

61. SIGNATURE OF MEEKNESS CLERK

62. SIGNATURE OF PATIENCE CLERK

63. SIGNATURE OF SELF-CONTROL CLERK

64. SIGNATURE OF MODERATION CLERK

65. SIGNATURE OF TEMPERANCE CLERK

66. SIGNATURE OF SINCERITY CLERK

67. SIGNATURE OF INTEGRITY CLERK

68. SIGNATURE OF HONESTY CLERK

69. SIGNATURE OF UPRIGHTNESS CLERK

70. SIGNATURE OF JUSTICE CLERK

71. SIGNATURE OF FAIRNESS CLERK

72. SIGNATURE OF EQUITY CLERK

73. SIGNATURE OF BALANCE CLERK

74. SIGNATURE OF PROPORTION CLERK

75. SIGNATURE OF ORDER CLERK

76. SIGNATURE OF REGULARITY CLERK

77. SIGNATURE OF SYSTEM CLERK

78. SIGNATURE OF METHOD CLERK

79. SIGNATURE OF FORM CLERK

80. SIGNATURE OF DESIGN CLERK

81. SIGNATURE OF PATTERN CLERK

82. SIGNATURE OF MODEL CLERK

83. SIGNATURE OF EXAMPLE CLERK

84. SIGNATURE OF STANDARD CLERK

85. SIGNATURE OF MEASURE CLERK

86. SIGNATURE OF CRITERION CLERK

87. SIGNATURE OF TEST CLERK

88. SIGNATURE OF TRIAL CLERK

89. SIGNATURE OF PROOF CLERK

90. SIGNATURE OF EVIDENCE CLERK

91. SIGNATURE OF FACT CLERK

92. SIGNATURE OF REALITY CLERK

93. SIGNATURE OF TRUTH CLERK

94. SIGNATURE OF VERITY CLERK

95. SIGNATURE OF FACTS CLERK

96. SIGNATURE OF REALITY CLERK

97. SIGNATURE OF ACTUALITY CLERK

98. SIGNATURE OF PRESENCE CLERK

99. SIGNATURE OF EXISTENCE CLERK

100. SIGNATURE OF BEING CLERK

101. SIGNATURE OF LIFE CLERK

102. SIGNATURE OF CONSCIOUSNESS CLERK

103. SIGNATURE OF AWARENESS CLERK

104. SIGNATURE OF KNOWLEDGE CLERK

105. SIGNATURE OF UNDERSTANDING CLERK

106. SIGNATURE OF WISDOM CLERK

107. SIGNATURE OF INTELLIGENCE CLERK

108. SIGNATURE OF REASON CLERK

109. SIGNATURE OF LOGIC CLERK

110. SIGNATURE OF PHILOSOPHY CLERK

111. SIGNATURE OF SCIENCE CLERK

112. SIGNATURE OF ART CLERK

113. SIGNATURE OF CRAFT CLERK

114. SIGNATURE OF TRADE CLERK

115. SIGNATURE OF VOCATION CLERK

116. SIGNATURE OF CAREER CLERK

117. SIGNATURE OF PROFESSION CLERK

118. SIGNATURE OF INDUSTRY CLERK

119. SIGNATURE OF DEDICATION CLERK

120. SIGNATURE OF COMMITMENT CLERK

121. SIGNATURE OF RESPONSIBILITY CLERK

122. SIGNATURE OF ACCOUNTABILITY CLERK

123. SIGNATURE OF OBLIGATION CLERK

124. SIGNATURE OF DUTY CLERK

125. SIGNATURE OF SERVICE CLERK

BUREAU V. S.

JAN 12 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00438

Reg. Dist. No. 81

1. PLACE OF DEATH COUNTY <u>CARROLL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>UNION BRIDGE</u> LENGTH OF STAY (In this place) <u>57 YRS.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>CARROLL</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>UNION BRIDGE</u> STREET ADDRESS (If rural give location) <u></u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>BLANCHARD DURBIN MARTIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-13-56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 20-1898</u>
9. AGE last birthday <u>57</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA A. MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>MAUDE HESSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>VIRGINIA LEE MARTIN Union Bridge Md.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.2 IMMEDIATE CAUSE (A) Acute Dilatation</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Chronic Myocarditis</u> (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <u></u>
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR? <u></u>	
22. I hereby certify that I attended the deceased from <u>March 19 1935</u> to <u>1-13-1956</u> , that I last saw the deceased alive on <u>Jan 12 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. H. Legg</u>		ADDRESS (Street, city, town, state) <u>Union Bridge Md.</u>	
DATE <u>Jan 16, 1956</u>		DATE SIGNED <u>1-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. DATE THEREOF <u>1-16-1956</u>	
25. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		26. LOCATION (City, town, or county) (State) <u>MD.</u>	
27. REC'D BY REGISTRAR <u>L. L. Reps</u>		28. REGISTRAR'S SIGNATURE <u>HB Bankard</u>	
29. FUNERAL DIRECTOR'S SIGNATURE <u>HB Bankard</u>		30. ADDRESS <u>Union Bridge Md.</u>	

CERTIFICATE OF DEATH

Form 100-1-1-1

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female) ☐ Male ☐ Female

3. DATE OF BIRTH (Month, Day, Year)

4. PLACE OF BIRTH (City, State, Country)

5. OCCUPATION (Print or Type)

6. MARITAL STATUS (Single, Married, Widowed, Divorced)

7. US BIRTH (Yes or No) ☐ Yes ☐ No

8. DATE OF DEATH (Month, Day, Year)

9. TIME OF DEATH (Hour, Minute)

10. PLACE OF DEATH (City, State, Country)

11. CAUSE OF DEATH (Print or Type)

12. MANNER OF DEATH (Print or Type)

13. SIGNATURE OF PHYSICIAN (Print or Type)

14. SIGNATURE OF REGISTRAR (Print or Type)

15. SIGNATURE OF WITNESS (Print or Type)

16. SIGNATURE OF DECEASED (Print or Type)

17. SIGNATURE OF NEXT OF KIN (Print or Type)

18. SIGNATURE OF CLERK (Print or Type)

19. SIGNATURE OF CHURCH CLERK (Print or Type)

20. SIGNATURE OF BURIAL CLERK (Print or Type)

21. SIGNATURE OF INTERMENT CLERK (Print or Type)

22. SIGNATURE OF CREMATION CLERK (Print or Type)

23. SIGNATURE OF OTHER CLERK (Print or Type)

24. SIGNATURE OF OTHER CLERK (Print or Type)

25. SIGNATURE OF OTHER CLERK (Print or Type)

26. SIGNATURE OF OTHER CLERK (Print or Type)

27. SIGNATURE OF OTHER CLERK (Print or Type)

28. SIGNATURE OF OTHER CLERK (Print or Type)

29. SIGNATURE OF OTHER CLERK (Print or Type)

30. SIGNATURE OF OTHER CLERK (Print or Type)

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female) ☐ Male ☐ Female

3. DATE OF BIRTH (Month, Day, Year)

4. PLACE OF BIRTH (City, State, Country)

5. OCCUPATION (Print or Type)

6. MARITAL STATUS (Single, Married, Widowed, Divorced)

7. US BIRTH (Yes or No) ☐ Yes ☐ No

8. DATE OF DEATH (Month, Day, Year)

9. TIME OF DEATH (Hour, Minute)

10. PLACE OF DEATH (City, State, Country)

11. CAUSE OF DEATH (Print or Type)

12. MANNER OF DEATH (Print or Type)

13. SIGNATURE OF PHYSICIAN (Print or Type)

14. SIGNATURE OF REGISTRAR (Print or Type)

15. SIGNATURE OF WITNESS (Print or Type)

16. SIGNATURE OF DECEASED (Print or Type)

17. SIGNATURE OF NEXT OF KIN (Print or Type)

18. SIGNATURE OF CLERK (Print or Type)

19. SIGNATURE OF CHURCH CLERK (Print or Type)

20. SIGNATURE OF BURIAL CLERK (Print or Type)

21. SIGNATURE OF CREMATION CLERK (Print or Type)

22. SIGNATURE OF OTHER CLERK (Print or Type)

23. SIGNATURE OF OTHER CLERK (Print or Type)

24. SIGNATURE OF OTHER CLERK (Print or Type)

25. SIGNATURE OF OTHER CLERK (Print or Type)

26. SIGNATURE OF OTHER CLERK (Print or Type)

27. SIGNATURE OF OTHER CLERK (Print or Type)

28. SIGNATURE OF OTHER CLERK (Print or Type)

29. SIGNATURE OF OTHER CLERK (Print or Type)

BUREAU V. S.

JAN 23 1956

RECEIVED

PHOTOCOPYED

RECEIVED JAN 23 1956

00439

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450 CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH - COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle) <u>Gibbons</u>	(Last) <u>Megee</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 26, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Megee</u>		14. MOTHER'S MAIDEN NAME <u>Ella Crass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY No. <u>213-05-3142</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Elsie Megee, Taneytown, Maryland</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>260x Anteriosclerotic Cardiovascular Disease</u>		<u>10 yrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(b) <u>Chronic Glomerulonephritis</u>		<u>10 yrs.</u>
(c) <u>Diabetes Mellitus - Insid</u>		<u>20 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Arteriosclerosis</u>		<u>15 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/10, 1951, to Jan. 3, 1956, that I last saw the deceased alive on Jan. 3, 1956, and that death occurred at 1:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/7/56</u>	NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	LOCATION (City, town, or county) <u>Taneytown, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan. 4, 1956</u>	REGISTRAR'S SIGNATURE <u>Ethel M. Megee</u>	24. FUNERAL DIRECTOR <u>C.O. Fuss & Son, Taneytown, Maryland</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1951
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00440
74

CERTIFICATE OF DEATH

Reg. Dist. No. 147

451

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Sykesville</i>		<i>since 9-19-55</i>		TOWN <i>Brunswick</i>		<i>10-35-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Springfield State Hospital</i>				STREET ADDRESS <i>532 W Potomac Str.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Hilda</i> (Middle) <i>Moore</i> (Last)				(Month) <i>1</i> (Day) <i>15</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>12-26-1918</i>	9. AGE last birthday <i>37</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>David Moore</i>				14. MOTHER'S MAIDEN NAME <i>Minnie Stride</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Paul Myers Brunswick Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
491X IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>						<i>days</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Mental deficiency</i>						<i>Life</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-19-1955</i>, to <i>1-15-1956</i>, that I last saw the deceased alive on <i>1-14-1956</i>, and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		ADDRESS (Street, city, town, state) <i>Springfield State Hospital</i>		DATE SIGNED <i>1/15/56</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>1-17-56</i>	NAME OF CEMETERY OR CREMATORY <i>Park Heights</i>		LOCATION (City, town, or county) (State) <i>Brunswick Md</i>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Eugene H. Buck</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>C. H. Felt</i>		ADDRESS <i>Brunswick Md</i>			
DATE <i>1-20-56</i>	<i>C. Harry Green</i>						

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. S.

JAN 28 1956

RECEIVED

PROTESTANT

1. Name of deceased: [illegible]
 2. Sex: [illegible]
 3. Race: [illegible]
 4. Date of birth: [illegible]
 5. Place of birth: [illegible]
 6. Date of death: [illegible]
 7. Place of death: [illegible]
 8. Cause of death: [illegible]
 9. Manner of death: [illegible]
 10. Signature of physician: [illegible]
 11. Signature of registrar: [illegible]
 12. Date of registration: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 81

452

1. PLACE OF DEATH:

COUNTY Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY (in this place)

TOWN Union Bridge

2 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Pleasant Valley

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Mary

Etta

Myers

4. DATE OF DEATH:

(Month) (Day) (Year)

Jan. 6

19 56.

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed

8. DATE OF BIRTH:

Jan. 14, 1882

9. AGE last birthday:

73 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

housework

10b. KIND OF BUSINESS OR INDUSTRY:

own home

11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

David R. Petry

14. MOTHER'S MAIDEN NAME:

Sarah H. Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

C. Roscoe Myers, Union Bridge, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from...*Sept 1, 1955*... to...*Jan 6, 1956*... that I last saw the deceased alive on...*1-4-*... 1956, and that death occurred at...*4 P.M.*... from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 10, 1956

Philip J. Kieffe

C.O. Fuss & Son

Taneytown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 12 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

453

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>1 month 5 days</u>		TOWN <u>Baltimore (24)</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15</u> <u>Springfield State Hospital</u>				<u>3405 Foster Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MATHILDA</u> <u>NAPOLILLO</u>				<u>1</u> <u>11</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>3-15-99</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Faulstich</u>				<u>Catherine Elsesser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>No</u>					<u>Hospital records</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>600.0</u> IMMEDIATE CAUSE (A) <u>Pyonephrosis</u>							<u>Months</u>
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Involuntional psychotic reaction.</u>							<u>2 months +</u>
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>12-14</u>....., 19<u>55</u>....., to <u>1-11</u>....., 19<u>56</u>....., that I last saw the deceased alive on <u>1-10</u>....., 19<u>56</u>....., and that death occurred at <u>4:45 A.M.</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Walter H. Sonnenfeldt</u> M.D.				<u>Sykesville, Maryland</u>		<u>1-11-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-14-56</u>		<u>SACRED HEART CEM.</u>		<u>1401 GERMAN HILL RD. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>IAN 16 1956</u>		<u>C. Mary Myers</u>		<u>Charles S. Zeller</u>		<u>901 S. CONKLING ST. BALTO., MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Page No. 12

LOCAL REGISTRAR (NAME OF REGISTRAR)

PLACE OF DEATH

DATE OF DEATH

Cause of Death

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. S.

JAN 10 1956

RECEIVED

UNRECORDED

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00443

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>18Y 4M 19 D</u>		TOWN <u>Chestertown</u>		<u>14-37-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>520 High Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry E. Perry</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>5</u> (Year) <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/8/92 - 2/8/91</u>		9. AGE last birthday <u>63-64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Perry</u>				14. MOTHER'S MAIDEN NAME <u>Ella Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Tuberculosis of the pericardium</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bilateral pulmonary tuberculosis, arrested</u>						<u>19 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Manic depressive reaction, depressive type</u>						<u>25 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> N.			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1/2</u> , 19 <u>56</u> , to <u>1/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>56</u> , and that death occurred at <u>9:55A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Woods</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>			
DATE <u>JAN 9 1956</u>		ADDRESS <u>Chestertown, Md</u>					

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

A. ABOUT BUSINESS (HOURS OF OCCURRENCE)

151

PLACE OF DEATH

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SEX

RACE

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NOTIFICATION

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS TO BE FILLED OUT BY THE PHYSICIAN WHO ATTENDS THE DECEASED, OR BY THE PERSON WHO HAS THE CUSTODY OF THE BODY, OR BY THE PERSON WHO HAS THE CUSTODY OF THE ESTATE OF THE DECEASED. IT IS TO BE FILED WITH THE LOCAL HEALTH DEPARTMENT, OR WITH THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

BUREAU V. S.

JAN 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00444

Reg. Dist. No. 26

1. PLACE OF DEATH COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) Westminster TOWN Westminster		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) Westminster TOWN Westminster	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 101 John St.		STREET ADDRESS (If rural give location) 101 John St.	
3. NAME OF DECEASED (Type or Print) (First) Anthony (Middle) - - - (Last) Pisasale		4. DATE OF DEATH (Month) Jan. (Day) 9 (Year) 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan. 15, 1877
9. AGE last birthday 78 yrs.		10. IF UNDER 1 YEAR (Months) 9 (Days) 19 (Hours) 56 (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressing Foreman Coat Factory		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. 213-05-1518	
17. INFORMANT & ADDRESS Mary Locascio Westminster, Md.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 432.1 IMMEDIATE CAUSE 1 (A) Cardiovascular disease ANTECEDENT CAUSE(S) DUE TO (B) arterio-sclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Severe bronchial asthma			INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years 20 years
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, term, factory, of injury street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) Jan. 10, 1956, 8:15 A.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 1956 , to Jan. 9, 1956 , that I last saw the deceased alive on Jan. 8, 1956 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. SIGNATURE C. H. Billingsley M.D. ADDRESS (Street, city, town, state) Westminster, Md. DATE SIGNED 1-10-56			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Jan. 12, 1956	
NAME OF CEMETERY OR CREMATORY Westminster		LOCATION (City, town, or county) (State) Westminster, Maryland	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Harriet Wolk		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.	
DATE 1-11-56			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED'S NAME (Last, first, middle)

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

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BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00445

CERTIFICATE OF DEATH

Reg. Dist. No. 80

455

1. PLACE OF DEATH COUNTY <u>Ch Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Ch Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - New Windsor</u> LENGTH OF STAY (In this place) <u>4 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - New Windsor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>W</u> (Last) <u>Purdum</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>21</u> (Year) <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1-15-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year: Months <u>1</u> Days <u>21</u> Hours <u>1</u> Min. <u>56</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William J. Purdum</u>		14. MOTHER'S MAIDEN NAME <u>Martha Molesworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Ther. Berns, Esq. Purdum, same</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
181X Immediate cause (a) <u>Cancer of bladder</u>			<u>10 to 15 mo.</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death. <u>anemia due to bleeding</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct 1, 1955, to Jan 21, 1956, that I last saw the deceased alive on Jan 21, 1956, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>1-25-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Locust Grove</u>	LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 24/56</u>	REGISTRAR'S SIGNATURE <u>Orwell Bendat</u>	24. FUNERAL DIRECTOR <u>L. M. Waltz</u>	ADDRESS <u>Winfield, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 25 1956

BUREAU V. S.

RECEIVED

FEB 15 1956

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00446

426

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>WESTMINSTER</u>				TOWN <u>WESTMINSTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 HERSH AVE.</u>				STREET ADDRESS (If rural give location) <u>7 HERSH AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ARTHUR</u> (Middle) <u>PETER</u> (Last) <u>REESE</u>				Month <u>1</u> Day <u>3</u> Year <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>WIDOWED</u>	<u>10-13-1872</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>FARM LABORER</u>						<u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U.S.A.</u>				<u>ABSLOM REESE</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			
<u>ALICE STANSBURY</u>				<u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>NONE</u>				<u>MARY REESE WESTMINSTER</u>			
18. MEDICAL CERTIFICATION				19. DATE OF OPERATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IMMEDIATE CAUSE (A) <u>Acute Coronary Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertensive heart Disease</u>				<u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/3</u> , 19 <u>56</u> , to <u>1/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/3</u> , 19 <u>56</u> , and that death occurred at <u>3:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Shirley B. Bon</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster, Maryland</u>			
DATE SIGNED <u>1/4/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>BURIAL</u>				<u>HARVEY MULLER</u>			
DATE THEREOF <u>JAN. 5, 1956</u>				NAME OF CEMETERY OR CREMATORY <u>WIDERS CEMETERY</u>			
LOCATION (City, town, or county) <u>WESTMINSTER, MD.</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvard P. Bon</u>			
ADDRESS <u>Westminster, Md.</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

CERTIFICATE OF DEATH

430

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of undertaker

15. Signature of funeral home

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of record

20. Signature of office

21. Signature of file

22. Signature of index

23. Signature of distribution

24. Signature of return

25. Signature of certificate

26. Signature of report

27. Signature of statement

28. Signature of declaration

29. Signature of affidavit

30. Signature of oath

31. Signature of promise

32. Signature of vow

33. Signature of pledge

34. Signature of compact

35. Signature of agreement

36. Signature of understanding

37. Signature of arrangement

38. Signature of contract

39. Signature of bargain

40. Signature of deal

41. Signature of transaction

42. Signature of business

43. Signature of affair

44. Signature of matter

45. Signature of thing

46. Signature of object

47. Signature of purpose

48. Signature of end

49. Signature of result

50. Signature of effect

51. Signature of consequence

52. Signature of issue

53. Signature of matter

54. Signature of thing

55. Signature of object

56. Signature of purpose

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59. Signature of effect

60. Signature of consequence

61. Signature of issue

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65. Signature of purpose

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264. Signature of end

265. Signature of result

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267. Signature of consequence

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269. Signature of matter

270. Signature of thing

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00447

456

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 2, Film GL92 1-31-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>11 month 7 days</u>		TOWN <u>Gaithersburg</u>		<u>Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS <u>Main Street</u> (If rural give location) <u>Asbury Methodist Home</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>DANIEL SCHOFIELD RICHARDS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 23 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-22-64</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Richards</u>				14. MOTHER'S MAIDEN NAME <u>Eliza J. Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4200 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						<u>Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with disturbance of metabolism, growth or nutrition with senile brain dis., psychotic react.</u>						<u>11 mo. +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>11-26</u> , 19 <u>55</u> , to <u>1-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>56</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Tommerfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-25-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hoffmanville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Turner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. L. Dauter</u>		ADDRESS	
DATE <u>Jan. 24, 1956</u>							

RECEIVED

JAN 26 1956

BUREAU V. S.

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. OCCUPATION: [illegible]

7. CAUSE OF DEATH: [illegible]

8. PLACE OF DEATH: [illegible]

9. DATE OF DEATH: [illegible]

10. SIGNATURE OF PHYSICIAN: [illegible]

11. SIGNATURE OF REGISTRAR: [illegible]

12. SIGNATURE OF WITNESS: [illegible]

PHOTOGRAPH

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

457

CERTIFICATE OF DEATH

01640

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>Since 9/17/52</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Knoxville - Maryland</u>		<u>218-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>Route #1</u>					
3. NAME OF DECEASED (Type or Print) <u>George Edward Rickards</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 10 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>September 10, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				More than 3 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Psychosis with senile brain disease</u>				More than 3 yrs			
19a. DATE OF OPERATION - - -		19b. MAJOR FINDINGS OF OPERATION - - -		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) - - -		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - -			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - -		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? - - -			
22. I hereby certify that I attended the deceased from <u>11/25/52</u> , to <u>Jan. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 10</u> , 19 <u>56</u> , and that death occurred at <u>9:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>1/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		NAME OF CEMETERY OR CREMATORY <u>GREEN ST</u>		LOCATION (City, town, or county) <u>M.D.</u>			
24. REC'D BY REGISTRAR <u>FEB 15 1956</u>		REGISTRAR'S SIGNATURE <u>C. Harry Cross</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dupel Bros</u>		ADDRESS <u>1806 LAMAR ST</u>	

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF OTHER OFFICIALS

BUREAU V. S.

FEB 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00448

458

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>9 month 20 days</u>		TOWN <u>Hampstead</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u> (Middle) <u>FREDERICK</u> (Last) <u>SAPP</u>				(Month) <u>1</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-31-87</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Sapp</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ella Sapp ASHE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk -</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, psychotic reaction.</u>						<u>4 yrs. +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-2</u> , 19 <u>55</u> , to <u>1-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>56</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1-2-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. REC'D BY REGISTRAR <u>1-4-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Wiser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton</u>		ADDRESS <u>Hampstead Md</u>	

1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

151

Page One, Re.

1. Name of deceased (Print or type)

2. Sex

3. Date of birth

4. Place of birth

5. Usual residence

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of funeral director

14. Signature of coroner

15. Signature of medical examiner

16. Signature of health officer

17. Signature of registrar

18. Signature of informant

19. Signature of funeral director

20. Signature of coroner

21. Signature of medical examiner

22. Signature of health officer

23. Signature of registrar

24. Signature of informant

25. Signature of funeral director

26. Signature of coroner

27. Signature of medical examiner

28. Signature of health officer

29. Signature of registrar

30. Signature of informant

31. Signature of funeral director

32. Signature of coroner

33. Signature of medical examiner

34. Signature of health officer

35. Signature of registrar

1. Name of deceased (Print or type)

2. Sex

3. Date of birth

4. Place of birth

5. Usual residence

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of funeral director

14. Signature of coroner

15. Signature of medical examiner

16. Signature of health officer

17. Signature of registrar

18. Signature of informant

19. Signature of funeral director

20. Signature of coroner

21. Signature of medical examiner

22. Signature of health officer

23. Signature of registrar

24. Signature of informant

25. Signature of funeral director

26. Signature of coroner

27. Signature of medical examiner

28. Signature of health officer

29. Signature of registrar

30. Signature of informant

31. Signature of funeral director

32. Signature of coroner

33. Signature of medical examiner

34. Signature of health officer

35. Signature of registrar

BUREAU V. 3

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00449

459

CERTIFICATE OF DEATH

Item 14, Film GL91 1-26-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>1yr. 7mo. 2days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>725 N. Lakewood Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>FRANCES SCHLIMM</u>				<u>Jan. 17 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>7-10-61</u>	<u>94</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>				<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Sinkenbrink</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia, unresolved</u>						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gangrene, both feet</u>						<u>1 month +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis, general</u>						<u>years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>CBS assoc. with disturbance of metabolism, growth or nutrition, senile brain dis., psychotic reaction.</u>						<u>1 1/2 yr. +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Fracture, right hip.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Hospital</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Sykesville Carroll Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11-24-55 9:30 A.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u>Patient fell.</u>			
22. I hereby certify that I attended the deceased from <u>6-21</u> , 19 <u>55</u> , to <u>1-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-16</u> , 19 <u>56</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Walter H. Sommerfeldt</u> M.D. <u>Sykesville, Maryland</u> DATE SIGNED <u>1-17-56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>1-19-56</u>		<u>Baltimore Cemetery</u>		<u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 18 1956</u>		<u>C. Harry Myers</u>		<u>Leo G. Cook</u>		<u>1700 Calverton Rd</u>	

CERTIFICATE OF DEATH

IN ARLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. USUAL RESIDENCE (HOME) OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. COUNTY

5. NAME OF DECEASED

6. SEX

7. AGE

8. RACE

9. DATE OF BIRTH

10. PLACE OF BIRTH

11. DATE OF DEATH

12. TIME OF DEATH

13. CAUSE OF DEATH

14. MANNER OF DEATH

15. PLACE OF DEATH

16. NAME OF DECEASED

17. DATE OF DEATH

18. TIME OF DEATH

19. CAUSE OF DEATH

20. MANNER OF DEATH

21. PLACE OF DEATH

22. NAME OF DECEASED

23. DATE OF DEATH

24. TIME OF DEATH

25. CAUSE OF DEATH

26. MANNER OF DEATH

27. PLACE OF DEATH

28. NAME OF DECEASED

29. DATE OF DEATH

30. TIME OF DEATH

31. CAUSE OF DEATH

32. MANNER OF DEATH

33. PLACE OF DEATH

34. NAME OF DECEASED

35. DATE OF DEATH

36. TIME OF DEATH

37. CAUSE OF DEATH

38. MANNER OF DEATH

39. PLACE OF DEATH

40. NAME OF DECEASED

41. DATE OF DEATH

42. TIME OF DEATH

43. CAUSE OF DEATH

44. MANNER OF DEATH

45. PLACE OF DEATH

46. NAME OF DECEASED

47. DATE OF DEATH

48. TIME OF DEATH

49. CAUSE OF DEATH

50. MANNER OF DEATH

51. PLACE OF DEATH

52. NAME OF DECEASED

53. DATE OF DEATH

54. TIME OF DEATH

55. CAUSE OF DEATH

56. MANNER OF DEATH

57. PLACE OF DEATH

58. NAME OF DECEASED

59. DATE OF DEATH

60. TIME OF DEATH

61. CAUSE OF DEATH

62. MANNER OF DEATH

BUREAU A. B.

JAN 19 1956

RECEIVED

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

460

00450

CERTIFICATE OF DEATH

Reg. Dist. No.

Springfield State Hospital

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carrroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore Ct.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Squiresville</u>		44 days		TOWN <u>Apparrows Point</u> 03X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
15 <u>Springfield State Hospital</u>				7012 River Drive Road. ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elizabeth</u> (Middle) <u>Kroll</u> (Last) <u>Schultz</u>				Jan. 21 19 56			
5. SEX	6. COLOR OF RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	White	Widowed	Jan. 12, 1874	82 782 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Employee - none		none		Germany		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
not known				Jeannette Kroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Hilda Meierschein 7012 River Drive Rd Baltimore 19. Md			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>arteriosclerosis cardio-vascular disease</u> years							
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u> years							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>C.B.S. associated with cerebral arteriosclerosis with psychotic reactions</u> months							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-8-55</u> , to <u>1-21-56</u> , that I last saw the deceased alive on <u>1-21-56</u> , and that death occurred at <u>6:30p.</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Walter H. Soumyfield</u>				<u>Springfield State Hosp.</u>		<u>1-22-56</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 25, 1956</u>		<u>Oaklawn</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>C. Harry Marx</u>		<u>Lassahn Funeral Home - 7401 Belair Rd.</u>			
DATE <u>Jan. 24, 1956</u>							

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX ☐ Male ☐ Female
 3. AGE (Years, months, days)
 4. DATE OF BIRTH (Month, day, year)
 5. PLACE OF BIRTH (City, State, Country)
 6. OCCUPATION (If any)

7. CAUSE OF DEATH (Immediate and underlying)
 8. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

9. SIGNATURE OF PHYSICIAN (If any)
 10. SIGNATURE OF REGISTRAR (If any)

11. SIGNATURE OF WITNESSES (If any)
 12. SIGNATURE OF DECEASED (If any)

13. SIGNATURE OF CLERK (If any)
 14. SIGNATURE OF CHIEF OF BUREAU (If any)

15. SIGNATURE OF DECEASED'S NEXT OF KIN (If any)
 16. SIGNATURE OF DECEASED'S ATTORNEY (If any)

17. SIGNATURE OF DECEASED'S MINISTER OF RELIGION (If any)
 18. SIGNATURE OF DECEASED'S CHURCH CLERK (If any)

BUREAU V. S.

JAN 24 1956

RECEIVED

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00451

461

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Sykesville</u>		<u>2yr. 4months</u>		Baltimore		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2011 East 30th Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>REINHARD</u> (Middle) (Last) <u>SCHULZE, SR.</u>				(Month) <u>1</u> (Day) <u>22</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-19-1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Piano)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unk-</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Schulze</u>				14. MOTHER'S MAIDEN NAME <u>Emelie Poppe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Unk-</u>	17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
602X IMMEDIATE CAUSE (A) <u>Bronchopneumonia, unresolved</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pyelonephritis</u>						<u>Months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Urinary calculus in the bladder</u>						<u>Unknown</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with disturbance of growth, metabolism, or nutrition, with senile brain disease.</u>						<u>Years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-13</u> , 19 <u>55</u> , to <u>1-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>56</u> , and that death occurred at <u>10:25P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/26/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Teller</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck, 5305 Harford Road #14</u>			
DATE <u>Jan. 25, 1956</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

ATTEST: HEALTH COMMISSIONER OF MARYLAND

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
SEX		AGE		OCCUPATION	
EDUCATION		MARRIAGE		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
SIGNATURE OF HEALTH COMMISSIONER		SIGNATURE OF CLERK		SIGNATURE OF JUDGE	

BUREAU V. E.

JAN 26 1956

RECEIVED

DECLARATIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00452

Reg. Dist. No. 70

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cumae</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>SUFFOLK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Westminster</u>		<u>14 mo</u>		TOWN <u>BRIGHT WATERS</u>		<u>69 x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Meadow View Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARIE</u> (Middle) <u>A.</u> (Last) <u>SENELON</u>				(Month) <u>Jan</u> (Day) <u>18</u> (Year) <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>10-10-1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ecuador - S. America</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOAQUIN MORALES</u>				14. MOTHER'S MAIDEN NAME <u>ALICE Prevost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mr. Harold R. Jamieson Taneytown Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) <u>Arterio sclerotic C-V disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>year</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> 19 <u>55</u> , to <u>Jan</u> 19 <u>56</u> , that I last saw the deceased alive on <u>1-13</u> 19 <u>56</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. March</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster Md</u>		DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Taneytown Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan 20/1956</u>		REGISTRAR'S SIGNATURE <u>Ethel M. Mehring</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Faustson</u>		ADDRESS <u>Taneytown Maryland</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>since 10/1/29</u>		TOWN <u>Rocky Ridge</u>		<u>106-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS <u>Rural</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Samuel</u>		(Middle) <u>H.</u>		(Last) <u>SHERFEY</u>		(Month) <u>January</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>male</u>	<u>white</u>	<u>divorced</u>	<u>July 25, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Unk</u>		<u>Frederick County, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel D. Sherfey</u>				<u>Amanda Kump</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>unknown</u>		<u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE (A) <u>Diabetic coma</u>						<u>9 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<u>about 5 yrs.</u>	
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Cerebrovascular accident</u>						<u>more than 3 months</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office <u>bdy</u> , etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1</u> , 19 <u>47</u> , to <u>Jan. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 10</u> , 19 <u>56</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. Sykesville, Maryland</u>		DATE SIGNED <u>1/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-15-1956</u>		NAME OF CEMETERY <u>Mt. Hope</u>		LOCATION (City, town, or county) (State) <u>Woodsboro, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Zuer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Md.</u>	
DATE <u>Jan. 13, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

JAN 16 1955

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JAN 16 1955

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>9 mos. 3 days</u>		TOWN <u>Baltimore-24</u>		<u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>424 N. Luzerne Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elsie</u>		(Middle) <u>Ramould</u>		(Last) <u>Sims</u>		(Month) <u>1</u> (Day) <u>4</u> (Year) <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>5/9/00</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Sims</u>				14. MOTHER'S MAIDEN NAME <u>Mary Esther Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of the lung</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental deficiency, Mongolism</u>						<u>55 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>55</u> , to <u>1/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>56</u> , and that death occurred at <u>9:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Samuels</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Jan 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Fishery Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt Vernon Md</u>	
24. REC'D BY REGISTRAR <u>1-4-56</u>		REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Herman</u>		ADDRESS <u>Funeral Home</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

JAN 9 1956

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MARYLAND STATE DEPARTMENT OF HEALTH

00455

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2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Morrison</u>	(Middle) <u>Delomas</u>	(Last) <u>Smith</u>
4. DATE OF DEATH	(Month) <u>January</u>	(Day) <u>1</u>	(Year) <u>1956</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>August 3, 1866</u>
9. AGE last birthday <u>89</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Nail</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Rhoda Smith, R#1, Union Bridge, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF INJURY	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from Apr 2, 1955, to Jan 1, 1956 that I last saw the deceased alive on Dec 31, 1955, and that death occurred at 6 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/5/56	Lutheran Cemetery	Uniontown, Maryland	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
1/5/56	Margaret R. Englar	C.O. Fuss & Son,	Taneytown, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the

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CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Sykesville</u>		<u>21yr. 1mo. 12days</u>		OR TOWN <u>Baltimore City</u>		<u>2401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>820 W. Lexington Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LENA</u> <u>SPRINGER</u>				<u>1-</u> <u>23</u> <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>5-25-83</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Delaware</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Abbott</u>				<u>Rose Allen Abbott Barcus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>No</u>					<u>Hospital records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>General arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with convulsive disorder, psychotic react.</u>						<u>21 yr. +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-20</u>, 19 <u>56</u>, to <u>1-23</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>1-23</u>, 19 <u>56</u>, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sommerfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>1-24-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>4/30/56</u>		<u>U of Md. Med. School</u>		<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>EB 15 1956</u>		<u>C. Harry Harris</u>					

1004 CERTIFICATE OF DEATH

REG. NO. 1004

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CHURCH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00456

427

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town) Westminster		LENGTH OF STAY (If in this place) 15 years		CITY (If outside corporate limits, write RURAL and give nearest town) Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Penna. Ave. Extd.		STREET ADDRESS (If rural give location) Penna. Ave. Extd.					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) Treva		(Middle) Elizabeth		(Last) Upperco		Jan. 2 19 56	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 10, 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hampstead, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John U. Leister				14. MOTHER'S MAIDEN NAME Emma Brilhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Leon R. Upperco Westminster, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/7, 1950, to 1/2, 1956, that I last saw the deceased alive on 1/1, 1956, and that death occurred at 11:15 A.M. from the causes and on the date stated above.							
SIGNATURE Julius Chepko		M.D. 130 E Green		ADDRESS (Street, city, town, state) Westminster		DATE SIGNED 1/3/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 5, 1955		NAME OF CEMETERY OR CREMATORY St. Paul's		LOCATION (City, town, or county) (State) Arcadia, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Harold Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers			
DATE 1-6-56				ADDRESS Westminster, Md.			

CERTIFICATE OF DEATH

1931

Reg. Dist. No.

2. EXACT NAMED PLACE OF DEATH

3. PLACE OF DEATH

1. NAME OF DECEASED
 John E. Smith
 1000 1st St.
 Baltimore, Md.

2. SEX
 Male
 3. AGE
 45
 4. OCCUPATION
 Clerk

5. DATE OF DEATH
 Jan 10, 1931

6. TIME OF DEATH
 10:30 AM

7. CAUSE OF DEATH
 Heart Disease

8. MANNER OF DEATH
 Natural

9. SIGNATURE OF PHYSICIAN
 J. E. Smith

10. SIGNATURE OF REGISTRAR
 J. E. Smith

11. SIGNATURE OF WITNESSES
 J. E. Smith

12. SIGNATURE OF DECEASED
 J. E. Smith

13. SIGNATURE OF DECEASED'S NEAREST RELATIVE
 J. E. Smith

14. SIGNATURE OF DECEASED'S NEAREST RELATIVE
 J. E. Smith

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 J. E. Smith

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33. SIGNATURE OF DECEASED'S NEAREST RELATIVE
 J. E. Smith

34. SIGNATURE OF DECEASED'S NEAREST RELATIVE
 J. E. Smith

BUREAU V. S.

JAN 9 1931

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00457

466

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CARROLL		MARYLAND		STATE Md.		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN SYKESVILLE		5 yrs; 3 mos.		TOWN GLEN ECHO		15X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
15 SPRINGFIELD STATE HOSP.							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ANNA		(Middle) MAE		(Last) YERKES		(Month) JAN (Day) 19 (Year) 56	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	WIDOW	JAN. 25, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housekeeper		Home		Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE F. FIFER				MARY BURNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk		Unk		Hospital Records			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A)				UREMIA			
ANTECEDENT CAUSE(S) DUE TO				ARTERIOSCLEROSIS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				CBS associated with Senility			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-5, 1950, to 1-19, 1956, that I last saw the deceased alive on 1-19, 1956, and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
James L. Hoffman		1/24/56		Greenmount Cemetery		Baltimore, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Burial		REGISTRAR'S SIGNATURE		The P. H. Jones Co.		2901 14th St. NW Wash, D.C.	
DATE Jan. 24, 1956		C. Harry Wilson					

BUREAU V. S.

JAN 26 1956

RECEIVED